

MIDWESTERN DENTAL PLANS, INC.

PROCEDURE

PATIENT COST

DIAGNOSTIC

Charting history, oral examinations, periodic recall Examination (every 6 months), emergency treatment	No charge
Emergency out-of-area (up to 50 mile radius) Reimbursement upon paid receipt from dentist (up to 50%)	

RADIOGRAPHIC

Complete intraoral series, periapical and bitewing films	No charge
Intraoral periapical	No charge
Each additional single film (periapical or bitewing)	No charge
Occlusal view x-ray	No charge
Lateral jaw x-ray each	No charge
Four bitewing x-ray films	No charge
Anterior-posterior x-ray of head and jaw	No charge
Cephalometric examination	No charge
Panoramic (panography) including bitewings.	No charge

PREVENTIVE

Oral prophylaxis (every 6 months)	No charge
Topical fluoride treatment following prophylaxis	No charge
Space maintainers – unilateral	No charge
Space maintainers – bilateral	No charge

OPERATIVE (RESTORATIVE) SERVICES

Primary silver amalgam – 1 surface	No charge
Primary silver amalgam – 2 surfaces	No charge
Primary silver amalgam – 3 surfaces or more	No charge
Permanent silver amalgam – 1 surface	No charge
Permanent silver amalgam – 2 surfaces	No charge
Permanent silver amalgam – 3 surfaces or more	No charge
Silver amalgam reinforcement pins – 1 st	No charge
---each additional pin	No charge
Composite filling (for front teeth)	No charge
Composite Class III	No charge
Composite Class IV	No charge
Composite post and core, or any build up	No charge

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PERIODONTIA

Root scaling and root planing (per quadrant)	No charge
Gingivectomy, Gingivoplasty (per quadrant)	No charge
Occlusal adjustments (and/or equilibration)	No charge
Bite guards	No charge
Osseous surgery (per quadrant)	No charge

ENDODONTICS (including radiographs)

Single root canal filling	No charge
Double root canal filling	No charge
Triple or more root canal filling	No charge
Apicoectomy	No charge

SIMPLE EXTRACTIONS (including local anesthesia)

Single tooth	No charge
Each additional tooth	No charge

ORAL SURGERY EXTRACTIONS (including local anesthesia)

Extraction of erupted tooth	No charge
Extraction of tooth (soft tissue impaction)	No charge
Extraction of tooth (partial bony impaction)	No charge
Extraction of tooth (complete bony impaction)	No charge
Alveoplasty/alveolectomy (per jaw maximums) per quadrant in conjunction with extraction	No charge
Alveoplasty, including ridge extension, arch	No charge
Excision of benign tumor, lesion diameter up to 2.5 cm.	No charge
Removal of cyst up to 2.5 cm. diameter	No charge

PROSTHETICS (including adjustments and relines for 6 months following installation)

Full upper denture	No charge
Full lower denture	No charge
Partial upper or lower denture without clasps, acrylic base	No charge
Partial upper or lower denture with two chrome clasps with rests, acrylic base	No charge
Partial upper or lower with chrome lingual or palatal bar with two clasps and rests, acrylic base	No charge
Repair broken full or partial dentures, no teeth damaged	No charge

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Repair broken full or partial dentures, replace broken tooth	No charge
each additional tooth	No charge
Repair broken tooth on denture, no other repairs	No charge
each additional tooth	No charge
Adding tooth to partial denture to replace extracted tooth	No charge
each additional tooth	No charge
Reattaching clasp on denture, clasp intact	No charge
Replacing broken clasp with new clasp on denture	No charge
Relining upper or lower full or partial denture (office)	
once every three years	No charge
Relining upper or lower full or partial denture (lab)	
once every three years	No charge
Jump case, complete denture (duplicate of denture)	
once every three years	No charge

CROWNS

Acrylic jacket	No charge
Acrylic with metal (semi-precious)	No charge
Porcelain jacket	No charge
Porcelain fused to metal (semi-precious)	No charge
¾ cast	No charge
Full cast	No charge

BRIDGE – PONTICS (fixed) *

Cast (per unit)	No charge
Maryland Bridge (per unit)	No charge
Porcelain fused to metal (semi-precious – per unit)	No charge
Plastic processed to metal (semi-precious – per unit)	No charge

*Refer to exclusion A24

ABUTMENTS

Two surface gold inlay	No charge
Three or more surfaces gold inlay	No charge

ORTHODONTIC BENEFITS

Orthodontic benefits include:

- Diagnosis, including models, photographs and cephalograms
- Active treatment
- Retention treatment

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ORTHODONTIC BENEFITS (cont.)

Active treatment will be rendered only for functional problems:

- a) One cusp deviation in the occlusion of the maxillary and mandibular arches
- b) Overbite – 4 mm. or greater
- c) Crossbites
- d) Overjets – 4 mm. or greater
- e) Crowding in excess of 4 mm.

Maximum twenty-four (24) months (to age 19)
Adult (19 years or older)

No charge
\$1,250.00

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EXCEPTIONS, EXCLUSIONS AND OTHER LIMITATIONS

- A. The term "Covered Dental Services" as used herein shall exclude the following:
1. Services for which Benefits are otherwise provided under a surgical-medical plan of the Group.
 2. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
 3. Prosthetic devices (including bridges, crowns, inlays, onlays and complete partial dentures and the fitting thereof) for which the final impressions were taken under this Agreement, or for which final impressions were taken while the individual was covered under this Agreement, but are not finally installed or delivered to such individual within sixty (60) days after the termination of coverage.
 4. Replacement or repair of an orthodontic appliance.
 5. Services which are compensated by Workers' Compensation or Employer's Liability.
 6. Dental services which are obtained by a Plan Member outside of the Dental Center in which he is enrolled and which are not pre-authorized by PLAN. This exclusion does not apply to Out-Of-Area Emergency dental services as defined in Article I.
 7. Services or supplies from any governmental agency which are obtained by the Plan Member outside without cost in compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body.
 8. Services to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof.
 9. Services for treatment of any automobile-related injury to the extent to which the Plan Member is covered under any no-fault automobile policy.
 10. Services rendered though any facility provided or maintained by the Plan Member's employer or such as a medical department or clinic.
 11. Services or supplies received for treatment of any dental disease, defect, accident or injury due to an act of war, declared or undeclared or participation or involvement in a riot or act of civil insurrection or during the commission of a felony.
 12. Elective dentistry or oral surgery.

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13. Services or supplies which do not meet accepted standards of dental practice, including services and supplies which are experimental in nature.
14. Treatment of fractures, dislocations, malignancies and neoplasms.
15. Treatment of myofacial pain syndrome, temporomandibular joint (TMJ), or temporomandibular dysfunction (TMD) is excluded.
16. Treatment to alter vertical dimension (except when involving full dentures and/or minor occlusal adjustments or orthodontic therapy).
17. Expenses of occlusal equilibration except to the extent necessary to treat periodontal disease.
18. Treatment of major congenital defects, such as cleft palates, congenitally missing teeth and associated deformities.
19. Implantology, (i.e., implants driven into or resting on a alveolar bone, used to support a crown, a full denture, or to act as an abutment for a fixed bridge when no abutment tooth is available or the surgical procedures on the jaws in preparation for the prosthesis). Both the surgical procedure and the prosthetic appliance are excluded.
20. Any duplicate prosthetic device or any other duplicate appliance.
21. Orthodontic treatment for a Plan Member subsequent to such person attaining the age of nineteen (19) unless said Plan Member is banded prior to his nineteenth (19) birthday or unless it is stated otherwise in the Schedule of Benefits. It is to be understood that said Plan Member remains eligible until the completion of Orthodontic treatment. Should eligibility be terminated, the Plan Member will be responsible for any unpaid balance.
22. Repair of full or partial dentures, except within six (6) months of delivery, after which the applicable co-payment will apply as identified in the Schedule of Benefits.
23. Replacement of an existing removable partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing removable or partial or to bridgework, unless:
 - a. Satisfactory evidence is presented that the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.
 - b. The existing denture or bridgework cannot be made serviceable and at least five (5) years have elapsed.

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- c. The existing denture is a temporary denture, which cannot be made permanent. The replacement by a permanent denture must take place within twelve (12) months on insertion of the immediate temporary denture.
- 24. All replacement of teeth where bilaterally edentulous (where teeth are missing on both sides of the same arch) area exist are to be performed with removable prosthesis as compared to a fixed prosthesis.
- 25. Retreatment of a completed orthodontic case. Orthodontic treatment is a once in a lifetime benefit.
- 26. Completion of orthodontic treatment for a patient who presents having prior orthodontic treatment of an inappropriate nature.
- 27. Sealants are not a covered benefit except as stated otherwise in the Group Schedule of Benefits.
- 28. Prosthetic services such as precision attachments, copings, over-dentures and stress breakers.
- 29. Gold teeth in removable prosthesis as well as clear palates in a complete upper denture.
- 30. Prescription drugs, laboratory tests and/or examinations, pre-medications and charges for hospitalization.
- 31. Orthognathic Surgery.
- 32. No coverage is provided due to the effects of abrasion, attrition or erosion, or as the result of injurious oral habits.
- 33. Services which were started prior to the individual enrolling in the Plan, e.g. root canals, crown and bridge, etc.
- 34. Treatment of unmanageable children or otherwise unruly patients. An attempt will be made to treat all patients. However, if a patient is untreatable by virtue of apprehension or for any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or with the guardian of the patient.
- 35. Services arising from any intentionally self-inflicted injury or contusion.
- 36. Services that can not be performed in the dental facility due to the general medical, mental or physical limitations of the Plan Member. The Plan Member is responsible for any cost incurred.

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37. Services which are necessitated by lack of patient cooperation or failure to follow a professionally prescribed treatment plan.
 38. Additional covered services, other than a dental emergency, if the Member has previously unresolved copayment balance that has been outstanding for sixty (60) or more days, unless special payment arrangements have been made within the primary care dentist or dental specialist.
 39. Full mouth reconstruction.
 40. Repairs to an old prosthesis that has been replaced with a new prosthesis.
 41. Continuation of orthodontic treatment where there has been greater than a six (6) month lapse in treatment.
- B. Limitations are defined as:
1. Full mouth or panoramic radiographs once every three years.
 2. Prophylaxes are covered twice in any contract year except as stated otherwise in the Group Schedule of Benefits.
 3. Fluoride is covered up to the age of nineteen (19).
 4. Single crowns, bridge abutments and pontics are covered for non-precious metals only.
 5. Root canal therapy is covered for traditional fill materials (gutta percha and silver points) and not Sargenti type materials.
 6. Repairs to an old prosthesis that has been replaced with a new prosthesis are not a covered benefit.
 7. Relines on traditional dentures are covered beginning six (6) months after delivery then once every three years after that. Relines on immediate dentures can be done anytime after delivery (no six month wait necessary) and then once every three years. There is no differentiation between lab and office relines or soft versus hard relines with regard to the same limitations.
 8. All adjustments to complete or partial dentures are covered for six months after delivery. After that time, a separate charge will be made for adjustments to either the upper or lower prosthesis or both in accordance with the Schedule of Benefits.
 9. Repairs, replacement or retreatments of restorations or endodontics are performed at no charge for twenty-four (24) months. After that time, the applicable copayment will apply as identified in the Schedule of Benefits.

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10. If any of the procedures performed in Oral Surgery and Periodontics are covered under any medical benefit plan(s), then exception AI would apply.
11. Orthodontics, for those Groups providing an orthodontic Benefit, is covered until the age of nineteen (19) unless stated otherwise in the Group Schedule of Benefits.
12. Optional Treatment: In all cases in which the Plan Member selects a more expensive service or benefit than is customarily provided or for which the Plan does not believe a valid dental need is shown, the Plan will allow for the applicable percentage of the fee for the service or benefit, if any, which is customarily provided to restore the tooth to contour and function. Fee of the lesser service or benefit to be applied toward the elected procedure. The Plan Member will pay the difference.

EXAMPLE:

A tooth can be satisfactory restored with amalgam. The Plan Member, however, chooses to have the tooth restored with a more costly material. The Plan will only provide for the applicable amount that it would have allowed to restore the tooth with amalgam. The Plan Member is responsible for the difference in cost.

13. Authorized or Covered Dental Services incurred as a result of an emergency as defined in Article I shall be covered limited to a maximum reimbursement of fifty dollars (\$50.00) (for the relief of pain and suffering) of the Plan's usual and customary and reasonable fee.

Out-Of-Area Emergency Procedures:

In the event a Plan Member experiences a dental emergency while out of the area, the individual should seek professional care to alleviate pain and suffering. A determination for reimbursement will be made and communicated to the Plan Member within five days of said claim. The claim for the services provided should be submitted to:

Midwestern Dental Plans, Inc.
5050 Schaefer Road
Dearborn, MI 48126

14. Dental services for individuals requiring additional or unusual efforts to complete a dental procedure, e.g. denture requiring obturation, microscopic procedures associated with root canals, surgical correction of dento-facial deformities, etc.
15. Retreatment of previously treated root canals while a member is limited to a three (3) year period.

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16. Retreatment of root canals completed prior to enrolling in the Plan will be subject to the Plan's usual, customary and reasonable fees for the retreatment of root canals. (Codes for retreatment are: Anterior: 3346, Bicuspid: 3347, Molar: 3348)

LIMITATIONS:

The following services will be subject to the limitations as set forth below:

- A. One (1) in a six month period:
 - 1. Periodic oral exam
 - 2. Routine prophylaxis
 - 3. Fluoride treatment
 - 4. Bitewing x-rays for dependents through the age of twelve (12) maximum four (4) per occurrence.
- B. One (1) in a twelve (12) month period:
 - 1. Bitewing x-rays for dependents through the age of thirteen (13) and over, maximum four (4) per occurrence.
- C. One (1) in a twenty-four (24) month period:
 - 1. Scaling and root planning
 - 2. Mucogingival surgery
 - 3. Osseous surgery
 - 4. Gingival flap per quad
 - 5. Gingivectomy per quad
 - 6. Gingivectomy per tooth
- D. One (1) in a three (3) year period:
 - 1. Full mouth series and panoramic x-rays
- E. One (1) in a five (5) year period (if found to be unserviceable):
 - 1. Complete dentures
 - 2. Partial dentures
 - 3. Fixed bridges
- F. One (1) per tooth per lifetime:
 - 1. Prefabricated stainless steel crowns – primary or permanent teeth
 - 2. Crown lengthening
- G. The following series are specifically limited to:
 - 1. Space Maintainers-
 - for dependent children through the age of eighteen (18) when used to maintain space as a result of prematurely lost deciduous teeth and

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permanent first molars or deciduous teeth and permanent molars or have not, or will not ever develop (see Schedule of Benefits)

2. Sealants-
 - for children through age fourteen (14) on a per tooth basis (see Schedule of Benefits)
 - not eligible within (3) years of placement unless provided by other than the original dental facility
- H. Orthodontics is a once in a lifetime benefit. If Orthodontic treatment has been completed elsewhere, there is no further benefit available under the Member's Plan. Members presently in orthodontic treatment at the time of enrolling in the Plan are eligible for treatment minus time already served in treatment.